

**DOUGLAS A. DUCEY**  
- GOVERNOR -



**VICTORIA WHITMORE**  
- EXECUTIVE DIRECTOR -

## **ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD**

1740 W. ADAMS ST., STE. 4600, PHOENIX, ARIZONA 85007

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### **INVESTIGATIVE DIVISION REPORT**

**TO:** Arizona State Veterinary Medical Examining Board

**FROM:** Investigative Division

**RE:** Case: 19-15

Complainant(s): Arizona State Veterinary Medical Examining Board

Respondent(s): Leslie Wootton, DVM (License: 1442)

#### **SUMMARY:**

Complaint Received at Board Office: 8/15/18

Board Discussion: 11/21/18

#### **APPLICABLE STATUTES AND RULES:**

Laws as Amended July 2014

Salmon); Rules as Revised

September 2013 (Yellow)

On August 15, 2018, the Board voted to open an investigation regarding Respondent's oversight of Tender Loving Care Veterinary Services & Supplies LLC (TLC) clinics, specifically at the Chandler Dogs 24/7 and Crismon Ace Hardware locations as related to the storing/handling/labeling of vaccines and expired medications on hand. Dr. Wootton is the Responsible Veterinarian for all TLC locations.

**PROPOSED 'FINDINGS of FACT':**

1. At the required premises inspection of the new TLC Crismon Ace Hardware on February 20, 2018, it was noted as a potential violation (R3-11-502(l)) that vaccines drawn ahead of needed administration were not labeled and there was no identifying information as to the type of vaccine in the syringe. The syringes of different types of vaccines were found in various compartments of a plastic container. The inspector suggested that the vial label be added to the syringe if vaccine syringes were going to be stockpiled in anticipation of use at a vaccine clinic.

At this inspection 3 bottles of expired medications were also identified (Heparin 11/17; Dexamethasone Sp 1/18; Kenalog 10, 1/18).

2. The TLC owner, Christian DeHaven, responded to the potential violation stating that he believed the administrative rule noted was incorrect, as the manufacturer does not have anything in print or on the vial or insert about handling of vaccines once taken out of the package. He expressed that the rule should be rewritten to express the Board's desire about pre-drawn medications; however, they would take the high road and enforce compliance of all pre-drawn medications to have a label on them for identification purposes.

3. Ms. Whitmore replied that she agreed that the correct administrative rule may not have been cited; she was researching and would get back to him.

4. On April 28, 2018, a premises inspection was conducted at the new TLC Chandler Dogs 24/7 location. It was noted as a potential violation (R3-11-501(1) this time) that pre-filled syringes of vaccines(presumably) were unmarked, found in various compartments of a plastic container.

5. Ms. Whitmore emailed Mr. DeHaven with the Inspection Report for Chandler Dogs 24/7, noting that unmarked pre-filled syringes were again found. She stated that she agreed that there is not an administrative rule that precisely says that a syringe must be labeled, therefore, R3-11-501(1), which references veterinarians needing to adhere to "professionally acceptable procedures" because no rule or law can contemplate every possible scenario.

Ms. Whitmore further explained to Mr. DeHaven that she would ask the Board to discuss this situation since there was still an issue.

6. At the May 2018 Board meeting, the Board discussed the issue that Ms. Whitmore brought to their attention, asking for direction on whether non-labeled syringes that have been filled prior to the vaccine clinic meets the standard of care for administering medications; inspection staff needs direction.

Ms. Whitmore had outlined several administrative rules (R3-11-802, R3-11-502(l), R3-11-501(1)) and one statute (ARS 32-2281(D)) that are related to the issue, but none specifically address either pre-filling syringes and/or using unlabeled syringes of medications.

7. At the May 2018 Board meeting, the Board discussed these issues and were most concerned

about the length of time that the vaccines were drawn up before use and that anything more than an hour prior would not be acceptable. This information was relayed to Mr. DeHaven. The Board also voted to open a complaint case.

8. At the June 2018 Board meeting, the Board again discussed the issue to provide further clarification to staff about unlabeled syringes and voted to rescind the vote to open a complaint case, as the license holder was allowed by law an opportunity to correct any deficiency the first time noted. The Board therefore directed staff to conduct follow-up inspections at TLC-ACE Crismon Hardware and Chandler Dogs 24/7 to verify whether unlabeled syringes are still in use and to encourage veterinary staff to not reconstitute/fill syringes more than an hour before use. If unlabeled syringes were found again, the Board may open a complaint case. This information was relayed to Mr. DeHaven.

9. On August 11, 2018, a follow-up inspection was completed at TLC-ACE Crismon Hardware at 4:10 p.m. Two expired medications were noted (cephalexin caps 250 mg, 7/18 and cephalexin caps 500 mg, 6/18). Also, it was noted that 5 pre-drawn unlabeled syringes were found in the plastic container with some syringes that were labeled as rabies vaccines and 5 pre-drawn unlabeled syringes were in a part of the container where nothing was labeled. Dr. Wootton stated that these were distemper vaccines.

Further conversation with Dr. Wootton noted that she stated that some syringes were drawn up that morning; they had done 3 other clinics that morning. A staff member, Karen, stated that the were drawn up on the way to the ACE Crismon location. This information and the Inspection Report was provided to Mr. DeHaven.

10. At the Board's August 15, 2018 meeting, the Board reviewed the TLC-ACE Crismon August Inspection Report. Mr. DeHaven made statements and answered questions. The Board voted to open an investigation regarding TLC's Responsible Veterinarian, Leslie Wootton, DVM for the practice of pre-drawing up syringes and other premises compliance issues.

11. On September 4, 2018, Dr. Wootton's response was received at the Board office. This included:

- the vaccines in question had only been in their separated box for 25 minutes and used within 1 hour of reconstitution. She noted that Merck Animal Health Guidelines state "once reconstituted are stable up to two (2) hours at room temperature." They base pre-draw preparation upon customer client counts from previous months and that pre-drawn vaccines were only done at the third and last clinic on August 11, 2018.
- There are times when after pre-drawing vaccines that labels may come off from moisture when housed in the container that is kept in the cooler. The labels that had come off were in the same separated area as the unconstituted vials and that every label was accounted for.
- There are multiple sections of the box that are easily identifiable by staff and veterinarians to prevent any vaccine confusion.
- Re: expired medications, those have been replaced and no expired medications have ever been dispensed to a client. Each month boxes are inspected for expired medications.

*The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.*

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Victoria Whitmore  
Executive Director

DOUGLAS A. DUCEY  
GOVERNOR



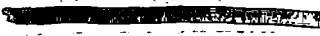
VICTORIA WHITMORE  
EXECUTIVE DIRECTOR

## ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

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CERTIFIED MAIL  
70150640000351021627

December 14, 2018

Leslie Wootton, DVM  
  


### **LETTER OF CONCERN – 19-15 - In Re: Leslie Wootton, DVM**

Dear Dr. Wootton:

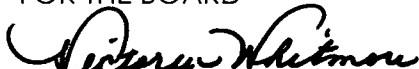
At its meeting on November 21, 2018 the Arizona State Veterinary Medical Examining Board ("Board") reviewed the complaint opened by the Board regarding information received at premises inspections of Tender Loving Care Veterinary Services & Supplies clinics. Specifically, there were concerns about unlabeled pre-drawn vaccine syringes and the length of time between drawing them up and administration. As well, some expired medications were found.

In each case, the Board considers the situation and the professional's response, as well as all relevant information. In this matter, after review and discussion, the Board voted to issue you a Letter of Concern pursuant to A.R.S. § 32-2234 (D) regarding the need follow veterinary medicine best practices concerning the storing, labeling, and administration of vaccines and monitoring medication supplies for expired products. This includes continuing to utilize your improvements of color-coding, enhanced staff training, and following manufacturer's guidelines about vaccine storing and timeframes for drawing up vaccines to time of administration.

A Letter of Concern is defined in A.R.S. § 32-2201(12) as "...an advisory letter to notify a veterinarian that, while there is insufficient evidence to support disciplinary action about certain aspects of the case, the Board believes the veterinarian should modify or eliminate certain practices and that continuation of the activities that led to the information being submitted to the Board may result in action against the veterinarian's license."

We hope you will take this advisory letter in the spirit that it is intended to avoid any other potential violations in the future.

Respectfully,  
FOR THE BOARD



Victoria Whitmore  
Executive Director

cc: Christian DeHaven, Tender Loving Care Veterinary Services & Supplies, LLC